

No. 2
1-10-39
-17-51
X216

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

13678

MAY 15 1940

791

State File No. _____

Registration District No. _____

Primary Registration District No. 1003

Registrar's No. 3880

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town St. Louis
(c) Name of hospital or institution St. Louis City Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____ years, months or days

3. (a) PRINT FULL NAME ROSIE OGRADY

3. (b) If veteran, name war _____ No. _____
8. (c) Social Security No. _____

4. Female 5. Color White 6. (a) Single, widowed, married, divorced Single
7. (b) Name of husband or wife _____ 8. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years about 50 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace Mass
(City, town, or county) (State or foreign country)

10. Usual occupation Domestic

11. Industry or business _____

12. Name Unknown

13. Birthplace _____
(City, town, or county) (State or foreign country)

14. Maiden name _____
15. Birthplace _____
(City, town, or county) (State or foreign country)

16. (a) Informant City Hospital
(b) Address _____

17. (a) _____ (b) Date thereof 4/15/40
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington St

18. (a) Signature of funeral director W. Richter 3500 Kuhn
(b) APR 30 1940

19. (a) _____ (b) _____
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 4313 No Broadway
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 3
year 1940 hour 5:10 minute _____ P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Lobar Pneumonia

Due to _____
Due to _____

Other conditions (include pregnancy within 3 months of death) _____

Major findings: Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury 3

23. Signature Joseph M. ... (M. D. or other)
Address Suburban ... Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

_____, Registered Apprentice No. _____

working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.